IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 13, 2007

Rita Berg, Administrator
Grace Memory Care of Nampa LLC
4356 North Nines Ridge Lane
Boise, ID 83702

License #: RC-781

Dear Ms. Berg:

On October 22, 2007, a complaint investigation, state licensure survey was conducted at Grace Memory Care of Nampa LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Karen McDaniel, R.N.

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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November 15, 2007

**CERTIFIED MAIL #: 7003 0500 0003 1967 0742**

Rita Berg, Administrator
Grace Memory Care of Nampa LLC
4356 North Nines Ridge Lane
Boise, ID 83702

Dear Ms. Berg:

Based on the complaint investigation, state licensure survey conducted by our staff at Grace Memory Care of Nampa LLC on **October 22, 2007,** we have determined that the facility failed to retain a licensed administrator responsible for the day-to-day operations of a single facility for a period of more than 30 days. The facility failed to protect residents from inadequate care. Based on observation, interview and record review it was determined the facility admitted and retained 2 of 7 sampled residents (#5, #6) for whom the facility did not have the capability, capacity and services to provide appropriate care. The facility also failed to obtain emergency services for 4 of 7 sampled residents (#1, #2, #5, and #6) and 5 random residents. This failure had the potential to affect 100% of the residents in the facility. Finally, the facility failed to develop and implement an interim plan of care or NSA for 3 of 7 sampled residents (#2, #5, and #6).

These core issue deficiencies substantially limits the capacity of Grace Memory Care of Nampa LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 6, 2007. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure

that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?

- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **November 28, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**November 28, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **November 28, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **November 22, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Grace Memory Care of Nampa LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Community Care Program

JS/sc

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13R781 | A. BUILDING _____ B. WING _____ | 10/22/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRACE MEMORY CARE OF NAMPA LLC | 422 11TH AVE SOUTH NAMPA, ID 83686 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| R 000 | Initial Comments<br><br>The following deficiency was cited during the standard health care survey and complaint investigation conducted at your residential care/assisted living facility. The surveyors conducting your health care survey were:<br><br>Polly Watt-Geier, MSW<br>Team Coordinator<br>Health Facility Surveyor<br><br>Donna Hensheid, LSW<br>Health Facility Surveyor<br><br>Karen McDannel, RN<br>Health Facility Surveyor<br><br>Survey Definitions:<br>ADA = American Dietetic Association<br>ALF = Assisted Living Facility<br>BID = Twice Daily<br>BLE = Bilateral Lower Extremities<br>BM = Bowel Movement<br>BP = Blood Pressure<br>CNA = Certified Nursing Assistant<br>ER = Emergency Room<br>Esp. = Especially<br>HH = Home Health<br>L = Liter<br>LOC = Level of Care<br>NSA = Negotiated Service Agreement<br>OT = Occupational Therapy<br>PO = By Mouth<br>PRN = As Needed<br>Pt. = Patient<br>PT = Physical Therapy<br>RN = Registered nurse<br>SBA = Stand By Assistance<br>SNV = Skilled nursing visit<br>TID = Three Times Daily | R 000 | | |

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| R 000 | Continued From page 1<br>UAI = Uniform Assessment Instrument<br>UTI = Urinary Tract Infection | R 000 | | |
| R 004 | 16.03.22.215.03 Licensed Administrator Requirement - 30 Days<br><br>The facility may not operate for more than thirty (30) days without a licensed administrator.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of a single facility for a period of more than 30 days.<br><br>During the complaint investigation and standard survey the facility's records were reviewed at the Licensing and Certification Agency. The records documented the administrator was the licensed administrator of the facility as of 11/27/05 and of the other building as of 3/7/06. Additionally, the records documented a variance request had been received by the department on 4/25/06. A handwritten note on the variance request dated 8/7/06 documented the "facility reports no longer needed" as each facility will have separate administrators. No variance was issued at that time.<br><br>On 10/16/07 at 11:15 AM the administrator stated she had been and is currently the licensed administrator for two facilities. She stated she had requested a variance from the Licensing and Certification Agency, but had heard no response.<br><br>The facility had operated for more than 30 days without a single licensed administrator responsible for the day-to-day operations. | R 004 | | |

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| R 008 | 16.03.22.520 Protect Residents from Inadequate Care.<br><br>The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record review it was determined the facility admitted and retained 2 of 6 sampled residents (#5 & #6) for whom the facility did not have the capability, capacity, and services to provide appropriate care. The facility also failed to obtain emergency services for 4 of 6 sampled residents (#1, #2, #5 and #6) and 5 random residents. This failure had the potential to affect 100% of the residents in the facility. Finally, the facility failed to develop and implement an interim plan of care or NSA for 3 of 6 sampled residents (#2, #5 and #6). The findings include:<br><br>I. Acceptable Admission and Retention of Residents<br>The facility's policies and procedures were reviewed on 10/16/07, a policy on acceptable admission and retention of residents was not found. The administrator confirmed the policies and procedures had not been updated at the facility, but the policies and procedures for the company had been updated and were used for all of the facilities. A different facility within the company's admission and discharge policy was reviewed on 10/18/07. It documented "no one will be admitted or retained who requires a type of service for which the facility is not licensed to provide or which the facility does not provide or if the facility does not have the personnel in the appropriate numbers and the appropriate skill (s) | R 008 | | |

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| R 008 | Continued From page 3<br>to provide such services."<br><br>Review of the facility's as worked schedule from January 2007 thru June 2007, revealed there was one caregiver scheduled on the night shift 11:00 p.m. to 7:00 a.m.<br><br>1. Review of Resident #5's record on 10/16/07 revealed he was admitted on 4/18/07 with diagnoses which included dementia, hypothyroidism, hyponatremia, petechial rash secondary to recent medications, prostatic hypertrophy and iron deficiency anemia.<br><br>A. Assistance of Mobility: Review of Hospital A's "Cumulative Assessment Chart Copy" dated 4/17/07 thru 4/18/07 documented, "Generalized weakness. Pt. up with the assistance of 2 people and a walker."<br><br>Resident #5's closed record contained Hospital A's "Last 24 hr Assessment Chart Copy" dated 4/18/07. It documented he required a sitter for supervision while in the hospital. It documented the resident needed a 2 person assist with mobility and was "very inconsistent with mobility and at risk for falls."<br><br>Review of Hospital A's discharge summary dated 4/18/07 documented Resident #5 wandered in the halls at the hospital and required the use of a walker and needed to "be monitored or have one-on-one attention when ambulating."<br><br>HH A's "Patient Summary/Physician Orders" dated 4/19/07 documented Resident #5 was found to be "lethargic" and had an inability to ambulate or speak and required maximum assistance of two caregivers for all transfers. It documented the assisted living facility was | R 008 | | |

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| R 008 | Continued From page 4<br>"willing to attempt cares."<br><br>HH A's physical therapy note dated 4/19/07 documented Resident #5 was "very groggy", weak and lethargic. It documented he was dependent on caregivers for all mobility. It also documented his balance was poor and required constant contact assistance to help maintain balance. It documented caregivers were "willing" to provide a 2 person assist as needed.<br><br>The facility's daily log note dated 4/20/07 on the 11-7 shift documented at 3:30 a.m., Resident #5 "had rolled out of the bed."<br><br>HH A's "Generic Nursing Intervention" dated 4/21/07 documented Resident #5 was "unable to ambulate." The resident's family members had planned to visit "frequently to assist" the facility with cares.<br><br>The facility's daily log note (undated) on the 11-7 shift documented while a caregiver was assisting Resident #5 at 11:30 PM from a chair to the toilet, he collapsed. The caregiver documented, "tried my best to get him to the bed." The caregiver found him kneeling on the floor at 1:30 AM and picked him up off of the floor because he would not participate in the transfer. The caregiver also documented that between 1:15 AM and 2:30 AM Resident #5 had been found on the floor 3 times and each time the caregiver had to pick him up. Additionally, Resident #5 was again found on the floor at 3:30 AM and was picked up and put in a chair. Resident #5 had 6 falls during this shift.<br><br>The facility's daily log note dated 4/22/07 on the 3-11 shift documented Resident #5 had been walking from one chair to another and fell while walking, "not hard no injuries. Another caregiver | R 008 | | |

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| R 008 | Continued From page 5<br>and I picked him up, he was fine, real hard to get back up on feet with 2 people."<br><br>The facility's daily log note dated 4/22/07 on the 11-7 shift documented Resident #5 was found at 3:30 AM kneeling on the floor and required assistance back into bed.<br><br>HH A's "Generic Nursing Intervention" dated 4/25/07 documented Resident #5 was up at night without sleeping much of the time. The resident, family members and caregivers were instructed to have the resident use a walker with all ambulation and transfers. Additionally, the resident had 3-4 unwitnessed falls during the night where he was found on the ground next to the bed.<br><br>HH A's physical therapy note dated 4/25/07 documented Resident #5 had "slipped last night or moved self out of chair or bed onto floor 5 times." It also documented that PT had visited the resident 4 times prior to the services being discontinued "due to caregiver request." The physical therapist further documented, "I believe, but do not know, that this [discontinuation of services] is due to caregiver being offended that we have concerns that patient may not be in appropriate level of care."<br><br>HH A's "Home Care Services Coordination of Care Records" dated 4/25/07 between 11:30 AM and 12:30 PM documented Resident #5 had "several falls" during the night where no injuries were noted, although it was documented he was very difficult to transfer off of the floor. He required 2 and 3 people for transfers and mobility due to the resident's confusion and weakness. The HH nurse expressed concern to the resident's family regarding the facility's ability to | R 008 | | |

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| R 008 | Continued From page 6<br>care for him. She encouraged the family to develop long range plans in care. The HH nurse also spoke with the house manager regarding the facility's ability to care for him at this "stage." The house manager "mentioned that her nurse is planning to give it another week."<br><br>The facility's daily log note dated 4/26/07 on the 3-11 shift documented Resident #5 was on the floor 4 times.<br><br>The facility's daily log note dated 4/26/07 on the 11-7 shift documented there were "6 residents [including Resident #5] all up, made popcorn and lemonade, needed to keep them occupied so I could do rounds. 3 residents [including Resident #5] all trying to go in others rooms."<br><br>The facility's daily log note dated 4/27/07 on the 3-11 shift documented Resident #5 wandered "around a lot won't stay in bed." He was found on the floor at 10:30 p.m., and the caregiver had to wait for another caregiver "to get him up."<br><br>The facility admitted and retained Resident #5 who required a 2 to 3 person assist with mobility and transfers. The facility was not able to care for Resident #5 because they had only one caregiver scheduled on the night shift from 11:00 PM-7:00 AM.<br><br>B. Urinary retention/catheter care: Review of Resident #5's closed record indicated he was admitted to the hospital on 4/28/07 and remained there for 10 days, then was re-admitted to the facility on 5/7/07. While hospitalized he had a Foley catheter placed and was discharged back to the facility with Home Health B, which was initiated on 5/8/07. | R 008 | | |

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| R 008 | Continued From page 7<br><br>HH B's nurses progress note dated 5/10/07 at 6:45 PM documented the HH nurse visited Resident #5 due to him trying to remove the catheter with the possibility it could have been removed traumatically. He had a "preoccupation" with the catheter and the family members "expressed their inability to sit with Pt. to prevent wrong doing." The HH nurse gave catheter instructions to family members, but there was no documented evidence the facility caregivers had received similar instructions or had been trained in catheter care. Additionally, the HH nurse "did advise [Family member] to eval Pt's need of care and consider whether current LOC is appropriate."<br><br>The facility's daily log note dated 5/10/07 on the 3-11 shift documented Resident #5 had pulled on the catheter and had some bleeding and pain, which the HH nurse evaluated. At around 9:20 PM a family member took him to the ER due to him not having any fluid in the catheter bag.<br><br>The facility's daily log note dated 5/10/07 on the 11-7 shift documented Resident #5 had not been complaining of pain, but he had been bleeding from the "penis" and the caregiver had cleaned the area twice. The caregiver documented "Everything seemed to be working properly emptied cath bag x 2."<br><br>The facility admitted and retained Resident #5 who required extensive supervision to monitor the resident's Foley catheter. There was no documented evidence the caregivers had not been trained regarding catheter care.<br><br>C. Fluid Restriction: Review of Hospital A's discharge summary dated 4/18/07 documented Resident #5 had "Hyponatremia, it appeared that | R 008 | | |

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| R 008 | Continued From page 8<br>the patient was drinking large amounts of water throughout the day." Discharge instructions included a 2200 calorie ADA diet with a 2 L fluid restriction.<br><br>A physician's order dated 4/18/07 documented Resident #5 was placed on a 2 L fluid restriction.<br><br>HH A's "Start or Resumption of Care" dated 4/19/07 documented the resident was on a 2 L fluid restriction.<br><br>Resident #5's closed record indicated HH A was discontinued on 4/27/07. On 4/28/07 the resident was admitted for an unresponsive episode to Hospital B and remained there for 10 days then was re-admitted to the facility on 5/7/07 with HH B.<br><br>Review of Hospital B's history and physical dated 4/28/07 documented Resident #5 had "a history of significant PO intake of fluids at that time, 6 to 9 liters per day." It documented he presented to the emergency room with a low sodium level, but not as "severe" as when he was at Hospital A. Additionally, it documented he had "evidence of fluid overload...will treat with Lasix and fluid restriction."<br><br>Review of HH B's "Home Health Certification and Plan of Care" dated 5/8/07 documented the HH agency was to assess nutrition and hydration status and compliance with fluid restrictions.<br><br>HH B's nurse progress note dated 5/8/07 documented Resident #5 continued "to be difficult to monitor with fluids, esp. water intake, and they will try hard diabetic candy, gum, ice chips. He did cooperate with me when I told him he could not have water, but this is problematic to the staff." | R 008 | | |

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| R 008 | Continued From page 9<br><br>Resident #5's record contained a "Fax transmission/phone order" dated 5/9/07 which documented, "Resident returned to this facility with 1500 ml (1.5 liter) fluid restriction. We need to have this order removed because resident is ambulatory with dementia. His fluid intake cannot be monitored in this setting." The physician responded "pt. has polydipsia with associated hyponatremia, fluid restriction is medically required!!"<br><br>The facility admitted and retained Resident #5 who required extensive monitoring of fluid intake. There was no documented evidence the facility had monitored his fluid intake from 4/18/07 to 4/28/07. Additionally, there was no documented evidence that when he was re-admitted on 5/7/07, the facility was able to ensure he complied with the ordered fluid restriction.<br><br>The facility admitted and retained Resident #5 who required extensive to total assistance with mobility, toileting and/or urinary conditions and fluid restrictions, which resulted in the resident being above LOC.<br><br>2. Resident #6 was admitted to the facility on 7/15/06 with diagnoses which included dementia, colon cancer, and macular degeneration.<br><br>On 5/14/07, a fax was sent to the physician documenting the resident had bruised the right hip and pelvis area and was unable to bear weight on that leg, "leg wobbly."<br><br>On 5/15/07, the resident was taken to the ER and admitted with a right pelvis fracture. The resident was re-admitted to the facility with a referral for HH on 5/21/07. | R 008 | | |

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| | 13R781 | A. BUILDING _____ B. WING _____ | 10/22/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| R 008 | Continued From page 10<br><br>Resident #6's closed record contained a hospital "Patient Transfer Form" dated 5/21/07, which documented she was non-weight bearing with the right lower extremity. A knee immobilizer was ordered PRN for non-weight bearing status.<br><br>Resident #6 was admitted to HH on 5/23/07. She was assessed as right non-weight bearing, unable to ambulate or to wheel self, unable to transfer self and unable to bear weight or pivot when transferred by another person. It also documented the resident had a large brace and would be assessed by PT and OT for proper use.<br><br>The facility's nurse's notes dated 5/26/07 documented Resident #6 was admitted to the hospital and was re-admitted to the facility on 5/29/07, with an order for hospice. On 5/31/07 the resident was admitted to hospice.<br><br>A hospice "Aide Intervention Sheet" dated 6/7/07 documented Resident #6 was a 2-3 person assist during cares.<br><br>A hospice "Aide Intervention Sheet" dated 6/8/07 documented Resident #6 was a 2 person transfer at all times.<br><br>On 10/16/07 at 10:35 AM the house manager confirmed there was only 1 caregiver scheduled at night but "if needed that person could call someone else to help."<br><br>On 10/16/07 at 11:00 AM a HH nurse stated after the Resident #6 was re-admitted on 5/21/07, the resident was unable to bear weight or pivot, unable to wheel herself and was totally dependent on staff for all of her cares. | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 11<br><br>On 10/16/07 at 11:15 AM the administrator stated she occasionally had reservations about admissions, but the owner of the facility would "override her decision on who was an acceptable admission and who was not."<br><br>On 10/16/07 at 11:30 a.m., when the facility RN was asked about residents who required a 2 person assist at night, the facility RN stated "if the resident is on hospice, the resident would be left in bed and turned every two hours. If the resident should fall during the night, when only one person is on, staff would call 911 to assist with getting the resident up."<br><br>The facility admitted and retained Residents' #5 and #6 who required a 2-3 person assist with mobility and transfers while having 1 caregiver on the night shift from 11:00 PM - 7:00 AM. Additionally, Resident #5 needed extensive to total assistance with toileting and/or urinary conditions and fluid restrictions for which the facility did not have the capability, capacity, and services to provide the appropriate cares.<br><br>II. Emergency Intervention<br>1. Review of Resident #5's closed record on 10/16/07 revealed the resident was admitted on 4/18/07 with diagnoses which included dementia, hypothyroidism, hyponatremia, purpuric rash secondary to recent medications, prostatic hypertrophy and iron deficiency anemia.<br><br>Resident #5's closed record contained Hospital A's "Last 24 hr Assessment Chart Copy" dated 4/18/07. It documented he needed a 2 person assist with mobility and was "very inconsistent with mobility and at risk for falls."<br><br>The facility's daily log note dated 4/22/07 on the | R 008 | | |

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| R 008 | Continued From page 12<br><br>3-11 shift documented Resident #5 had been walking from one chair to another and fell while walking "not hard no injuries. Another caregiver and I picked him up, he was fine, real hard to get back up on feet with 2 people." There was no documented evidence of an incident report being completed or if the nurse had been notified of the incident and assessed the resident.<br><br>The facility's daily log note dated 4/26/07 on the 3-11 shift documented Resident #5 was on the floor 4 times. There was no documented evidence of an incident report being completed or if the facility RN had been notified of the incidents and assessed or instructed the caregivers on how to care for the resident after the incidents.<br><br>The facility's daily log note dated 4/27/07 on the 3-11 shift documented Resident #5 wandered "around a lot won't stay in bed." The resident was found on the floor at 10:30 PM, and the caregiver had to wait for another caregiver "to get him up." There was no documented evidence of an incident report being completed or if the facility RN had been notified of the incident and assessed or instructed the caregivers on how to care for the resident after the incident.<br><br>The facility's daily log note dated 4/28/07 on the 7-3 shift documented Resident #5 was "unresponsive all day at 12:00, called 911 sent to hospital." There was no documented evidence of an incident report being completed or if the facility RN had been notified of the incident and assessed or instructed the caregivers on calling emergency services.<br><br>Review of Hospital B's history and physical dated 4/28/07 documented Resident #5 "presented to the emergency room via ambulance with a history | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 13<br>of unresponsiveness and inability to awaken him for approximately 8 hours. It started around 3-4 am on the morning of admission and continued till about 12 or 1 pm." "...they tried multiple ways of awakening him, he was just unresponsive but was with normal vitals. A home health nurse went to check on him as well and again his vitals were appropriate but he was unresponsive. They called the ambulance. "<br><br>Review of Resident #5's closed record indicated HH A was discontinued on 4/27/07. It also documented he was admitted for the unresponsive episode to Hospital B on 4/28/07. He remained at the hospital for 10 days and then was re-admitted to the facility on 5/7/07. While hospitalized the resident had a Foley catheter placed and was discharged back to the facility with HH B, which was initiated on 5/8/07.<br><br>HH B's nurse progress note dated 5/10/07 at 6:45 PM, documented the HH nurse visited Resident #5 after he tried to remove the catheter with the possibility of removing it traumatically. There was no documented evidence of an incident report being completed or if the facility RN had been notified of the incident and assessed or instructed the caregivers on calling emergency services or getting him medical attention.<br><br>The facility's daily log note dated 5/10/07 on the 3-11 shift documented Resident #5 had pulled on the catheter and had some bleeding and pain which the HH nurse evaluated. At around 9:20 PM, a family member took him to the ER due to there not being any fluid in the catheter bag. There was no indication the facility RN had instructed the caregivers on what to do if the catheter was not working properly. Additionally, when he had a change in condition the facility RN | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 14<br>was not involved and a family member took Resident #5 for medical care.<br><br>The facility's daily log note dated 5/10/07 on the 11-7 shift documented Resident #5 had not been complaining of pain, but the resident had been bleeding from the "penis" and the caregiver had cleaned the area twice. The caregiver documented "Everything seemed to be working properly emptied cath bag x 2." The facility RN had not given instructions to the caregivers during or after he had pulled out the catheter on what to monitor or how to ensure the catheter was working properly.<br><br>The facility's daily log note dated 5/16/07 on the 11-7 shift documented Resident #5's [family member] took the resident to the ER at 6:00 AM, as "the ER urinalysis strip showed traces of white/red blood cells in urine complaining of tremendous pain in abdomen." There was no documented evidence of an incident report being completed due to the resident having complained of pain. There also was no documented evidence the caregiver had notified the facility RN of the change in condition or that the facility RN had assessed or instructed the caregiver on the need for emergency services.<br><br>Hospital B's records documented Resident #5 was seen in the emergency room on 5/17/07 at 6:00 AM, for constant abdominal pain which began 2 days ago. At 8:07 AM, "the family called ALF. Pt has not had a BM since 5/14/07." He was admitted to the hospital on 5/17/07 with diagnoses which included: perforation of intestine and rentention of urine.<br><br>Hospital B's radiology results on 5/17/07 documented Resident #5 sustained a bowel | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 15<br>perforation and a "splenic fracture with adjacent subacute rib fracture."<br><br>On 10/17/07 at 9:38 AM, a family member stated the resident had many different issues at the time he was at the facility. She stated the resident needed supervision at night as the resident would become confused and would be up walking. She stated the resident would sometimes become weak all of a sudden and would fall, but not usually hard. She stated a caregiver had called her at one point and told her the resident had fallen and she could hardly get him up by herself. She stated she arrived at the facility in the early morning on 5/17/07. At that time the night caregiver told the family member the resident had been in pain all night. The caregiver also told the family member the resident had been asked during the night if a family member should be called and he had said no. The family member took him to the ER where it was determined he had a broken rib, punctured bowel and ruptured spleen.<br><br>On 10/17/07 at 10:03 AM, a second family member stated the resident needed assistance with mobility and when taking the resident to a physician's visit it took two family members to assist the resident with his walker. She stated she was not aware of any accidents or falls with injuries. She stated she was aware the resident had a BM 3 days prior to being admitted to the hospital on 5/17/07, but did not know if he had any others after that point. She stated she had taken him to the physician's office on 5/16/07, where at that time the resident had complained of stomach pain, but it was unclear there had been an injury. No falls had been reported to the family.<br><br>On 10/170/7 at 3:00 PM, a caregiver stated | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 16<br><br>Resident #5 required heavy care initially, then improved and then became worse again. He wandered all of the time and did not like to sit. Additionally, she stated she had never seen Resident #5 fall, but he was on the ground a lot and would get himself up.<br><br>The facility failed to obtain emergency intervention in a timely manner when Resident #5 had an unresponsive episode, injury after removing a catheter and when there were several falls without nursing assessments and interventions. Additionally, no emergency intervention was provided when he complained of pain for an extended period of time. He was later found to have a fractured rib, splenic fracture and perforated bowel.<br><br>2. Resident #6 was admitted to the facility on 7/15/06 with the following diagnoses: dementia, colon cancer and macular degeneration.<br><br>Resident #6's closed record contained a quarterly nursing assessment (2/07-4/07) which documented the resident was "alert, confused. Frequently appears anxious and verbally shouts, frequent falls from bed (alarm put on) following attempting to stand and walk while up in wheelchair."<br><br>An accident/incident report dated 1/19/07 at 1:30 PM, documented Resident #6 was found on the floor and first aid was applied to skin tear on the right elbow. There was no documentation the facility RN had been notified at the time of the incident and the facility RN signed the report on 1/29/07, 10 days after the incident occurred. Additionally, there was no documented evidence of an investigation, or that the facility RN had assessed her after the incident or had given | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 17<br>nursing instructions to the caregivers on how to care for her after the incident.<br><br>The daily log notes dated 1/22/07 on the 7-3 shift documented Resident #6 was given pain medication (not specified).<br><br>The daily log notes dated 1/28/07 on the 7-3 shift documented Resident #6 was having "a lot of pain, gave PRN (not specified), laying in bed most of the day." There was no documentation the facility RN had been notified.<br><br>The daily log notes dated 1/28/07 (shift not identified) documented Resident #6 was given hydrocodone 1/2 tablet for pain. There was no documentation the facility RN had been notified.<br><br>Resident #6's closed record contained a fax sent to the physician, which was dated 1/28/07. It documented the resident had fallen on 1/26/07 and had complained of pain in her hips. A request for a mobile x-ray was documented. The physician ordered the mobile x-ray on 1/29/07 and the nurse noted the order on 1/30/07. There was no documented evidence she had received medical care or emergency intervention after sustaining the fall and complaining of pain.<br><br>The daily log notes dated 1/29/07 on the 3-11 shift documented Resident #6 was given hydrocodone at 5:00 PM and 9:30 PM for pain. There was no documentation the facility RN had been notified.<br><br>An x-ray was taken of Resident #6's pelvis and bilateral hips on 1/30/07 and did not document any acute abnormalities. She had fallen on 1/26/07 and had an x-ray taken on 1/30/07, 4 days after the fall. | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 18<br><br>The daily log notes dated 2/1/07 on the 7-3 shift documented Resident #6 was in bed most of the day and continued to complain of back pain. There was no documentation the facility RN had been notified.<br><br>The daily log notes dated 2/1/07 on the 3-11 shift documented Resident #6 was given PRN medications (not specified) at 4:00 PM and 9:30 PM.<br><br>The daily log notes dated 2/2/07 on the 3-11 shift documented Resident #6 fell and hit her head, was complaining of back and head pain and was sent to the ER. There was no documented evidence an incident/accident report had been completed. The facility RN documented in the nurse's notes, "resident transports in wheelchair for safety."<br><br>The daily log notes dated 2/9/07 on the 3-11 shift documented Resident #6 was in pain, a "PRN" (not specified) was given and she was put to bed. There was no documentation the facility RN had been notified.<br><br>The daily log notes dated 2/12/07 on the 3-11 shift documented Resident #6 was given hydrocodone at 9:00 PM. There was no documentation the facility RN had been notified.<br><br>On 3/7/07 daily log notes for the 3-11 shift documented Resident #6 fell out of bed at 9:00 PM. The accident/incident report dated 3/7/07 documented the incident occurred at 8:15 PM. She was found on the floor and had one small scrape on the right elbow which was bandaged. She was given 2 Tylenols. There was no documentation the facility RN was notified of the | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 19<br>incident until the next day when the incident/accident report was signed as reviewed. Additionally, there was no documented evidence the facility RN had assessed her after the incident or had given nursing instructions to the caregivers on how to care for the resident after the incident.<br><br>The daily log notes dated 3/8/07 on the 7-3 shift documented Resident #6 had complained of pain and was given Tylenol. There was no documentation the facility RN had been notified.<br><br>The facility's nurse's note dated 3/9/07 documented Resident #6 was complaining of pain and holding anterior rib area when burping. The physician was notified per fax with a request for an x-ray which was granted. There was no documented evidence the resident had received medical care or emergency intervention after holding the anterior rib and burping.<br><br>An x-ray was completed on 3/12/07, which indicated Resident #6 had fractured her left ninth rib, 5 days after the resident fell. The nurse's notes documented she had sustained a fracture on 3/13/07. There was no documented evidence the facility RN had assessed Resident #6 after the incident or had given instructions to the caregivers on how to care for her.<br><br>An accident/incident report dated 3/30/07 at 3:45 PM documented Resident #6 was found on the floor and skin tears were cleaned and bandaged. There was no indication the facility RN was notified. There was no investigation or action taken. There was also no documentation the facility RN had assessed her or instructed the caregivers on how to care for her after the incident. | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 20<br><br>An accident/incident report dated 4/10/07 at 7:30 AM documented Resident #6 was found beside her bed, bleeding from her head and elbow. The unlicensed caregiver had documented, "did not see any need for stitches." The wound was cleaned and her clothing changed. There was no documented evidence she had received medical care or emergency intervention after being found bleeding from the head. Additionally, there was no documentation the facility RN had been notified or assessed her injury on the day it occurred. The report was signed by the facility RN as reviewed on 4/12/07, 2 days after the incident occurred.<br><br>An accident/incident report dated 4/29/07 at 4:24 PM documented Resident #6 fell from her wheelchair to the floor resulting in a large skin tear on the left forearm and small skin tear on left upper arm right above the elbow. She had a second fall and was "assessed" not to have any injury. At 6:23 PM she fell a third time in the bathroom which resulted in another small skin tear on left arm. The arm was treated and bandaged. There was no documentation the facility RN had been notified or had assessed her after sustaining 3 falls on the day they occurred. The report was signed by the facility RN on 5/2/07, 4 days after the falls occurred.<br><br>The daily log notes dated 5/10/07 on the 7-11 shift documented Resident #6 complained of pain in the leg. There was no documentation the facility RN was notified or had assessed her leg after complaints of pain.<br><br>The daily log notes dated 5/10/07 on the 3-11 shift documented Resident #6 was "very confused, complained of pain, ate nothing at | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 21<br>dinner and kept falling asleep and woke up screaming." There was no documentation the facility RN was notified or had assessed her.<br><br>The daily log notes dated 5/11/07 on the 3-11 shift documented Resident #6's legs were checked and the "pinky toe looks broken and she had complained earlier that it hurt." There was no accident/incident report found and no documentation the facility RN had been notified or had assessed her toe. Additionally, there was no documented evidence she had received medical care or emergency intervention after sustaining a possible broken toe.<br><br>An accident/incident report dated 5/12/07 (no time listed) documented Resident #6's leg rubbed against the wheelchair and caused the top layer of skin to tear. The wound was cleaned and bandaged. The accident/incident report was not signed by the facility RN and there was no documentation the facility RN had been notified or assessed the skin tear.<br><br>A fax dated 5/14/07, was sent to the physician documenting Resident #6 had a bruised right hip and pelvis area and was unable to bear weight on that leg, "leg wobbly." The request was for a mobile x-ray which the physician denied and said to send her to the ER. There was no documented evidence she was immediately taken to the emergency room as she was not seen until 5/15/07.<br><br>On 5/15/07 Resident #6 was taken to the ER and admitted with a right pelvis fracture. There had been no report of a fall since 4/29/07 (16 days) and on 4/29/07 she fell 3 times. She was admitted to the hospital to "keep comfortable, immobilize the hip and plan for discharge." | R 008 | | |

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|---|---|---|---|
| | 13R781 | A. BUILDING _____ B. WING _____ | 10/22/2007 |

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| GRACE MEMORY CARE OF NAMPA LLC | 422 11TH AVE SOUTH NAMPA, ID 83686 |

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| R 008 | Continued From page 22<br>Surgery was not elected per physician's recommendation.<br><br>On 10/16/07 at 3:20 PM a caregiver stated that in the event a resident falls the procedure is to "ask if they are okay or if they can stand up. If the resident says no, we call the family or the ER." Further, the caregiver admitted she had never called the nurse but did call the house manager once when a resident fell and hit her head. She said the house manager told her to call the daughter and the daughter said that it could wait.<br><br>On 10/16/07 at 3:25 PM a caregiver stated that in the event of an emergency the residents are "looked over, if something is wrong I call the family and if serious I call [house manager's name]. Further, the caregiver stated, "I really don't know how to tell if it's something serious, just by the look [of the resident] or the resident will tell me."<br><br>On 10/16/07 at 3:30 PM a caregiver stated the procedure in an emergency was to call 911 if choking or not breathing, otherwise to call the family and then the supervisor [house manager's name].<br><br>The facility failed to obtain emergency intervention and/or medical care in a timely manner when Resident #6 had sustained several skin tears, a laceration to the head, bruising, fractures and injuries from falls. The facility RN had not directed caregivers in the event of an incident/accident when to contact her or obtain emergency services.<br><br>3. Resident #2 was admitted to the facility on 8/19/04 with diagnoses including Alzheimer's Dementia. | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 23<br><br>An accident/incident report dated 9/19/07 documented Resident #2 called for help and was found on the floor at 7:30 AM. Under the "Treatment" section it documented the son was called and then the ambulance was called. The facility RN was called on 9/19/07 at 9:00 AM, 1 1/2 hours later. Emergency services were obtained after it was requested by a family member. The resident was hospitalized with a hip fracture.<br><br>On 10/19/07 at 2:43 PM a caregiver stated Resident #2 was found on the floor on 9/19/07 with her leg turned outwards and two staff members (including herself) transferred the resident into a wheelchair prior to obtaining emergency services. Additionally, she said the son was called and he said to send the resident to the ER.<br><br>The facility failed to obtain emergency intervention and/or medical care in a timely manner when Resident #2 had sustained a hip fracture. The facility RN had not directed caregivers in the event of an incident/accident when to contact her or obtain emergency services.<br><br>4. Incident Reports of One Identified and Six Random Residents<br><br>On 10/17/07 the incident/accident log was reviewed and revealed the following:<br>An incident report dated 5/28/07 at 5:02 PM documented Random Resident C was noted as "walking strange, he was leaning forward he also had three small cuts on his face: one to the side of his nose, one below the eyebrow, one below his eye." Random Resident C had difficulty | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 24<br>seeing to eat, "he kept putting his hands in his food to eat." It documented Random Resident C was treated by cleaning and bandaging his wounds. The nurse was notified by caregivers on 5/28/07 at 5:11 p.m., but the incident report did not document he had been assessed by the facility RN or if the caregivers were instructed on how to care for him after the incident.<br><br>An incident report dated 6/6/07 at 1:18 PM documented Random Resident A attempted to move a chair away from the table. It documented Random Resident A became unsteady and Random Resident B tried to assist Random Resident A to a chair. Both residents fell on their face. Random Resident A fell on the right side. There were no complaints of pain. Two caregivers assisted Random Resident A in the chair. Additionally, the resident refused the caregivers to check vitals. The incident report did not document if the nurse had been notified of the incident and there was no documented assessment completed of his condition after the incident.<br><br>An incident report dated 6/6/07 at 1:18 PM documented Random Resident B was sitting at a table and tried to assist Random Resident A into a chair. Both residents fell, but Random Resident B fell against the "arm of green chair." Random Resident B complained of pain to right elbow and right lower back "range of motion within normal range" and Resident B was assisted by two caregivers into a chair. The incident report did not document if the facility RN had been notified of the incident and there was no documented assessment completed of his condition after the incident.<br><br>An incident report dated 6/8/07 at 11:40 AM | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 25<br>documented Random Resident B was found on the floor after a caregiver heard a "thud" while cleaning up feces in his room. "I didn't see any injuries or bruises at that time. I got him into bed and asked him if he had any pain, he said no." The facility RN had signed the incident report on 6/15/07, 7 days after the incident. The incident report did not document if he had been assessed by the RN or if and when the caregivers were instructed on how to care for him after the incident.<br><br>An incident report dated 6/9/07 at 12:30 AM documented Random Resident A was found "on the floor with his underwear pulled down covered in BM. I believe he was there for a long time because poop was dry." The caregiver "called" another caregiver to come to the facility to assist with getting him into a wheelchair. The caregiver also documented, "he has so many cuts and bruises I can't tell if any are new. I cleaned room and put the resident to bed." The facility RN had signed the incident report on 6/15/07, 6 days after the incident. The incident report did not document he had been assessed by the RN or if and when the caregivers were instructed on how to care for him after the incident.<br><br>An incident report dated 6/27/07 at 8:50 AM documented Random Resident B "attempted to walk on his own after being put back in his wheelchair. He fell on the ground and hit his head on the counter." He was treated with a bandage to a "rug burn on his right knee." The incident report did not document if the RN had been notified of the incident and there was no documented assessment completed of his condition after the incident.<br><br>An incident report dated 7/13/07 at 5:00 AM | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 26<br>documented Random Resident E was found by her dresser in her room after a caregiver heard a loud noise. "Telfa dressing with ointment applied to open area on nose. Skid mark with swelling on forehead, open to air. Denies dizziness will continue to monitor." The incident report did not document if the facility RN had been notified of the incident and there was no documented assessment completed of her condition after the incident.<br><br>An incident report dated 7/14/07 at 4:00 PM documented Random Resident B."would not stay in his wheelchair, he fell 5 times, he had a little scrape on the top of his right eye". The facility RN had signed the incident report on 7/18/07, 4 days after the incident. The incident report did not document he had been assessed by the RN or if and when the caregivers were instructed on how to care for him after the incident.<br><br>An incident report dated 7/14/07 at 8:00 PM documented Random Resident B "was trying to get out of his wheelchair and lost his balance and fell. Looked him over he did not have any injuries." The facility RN had signed the incident report on 7/18/07, 4 days after the incident. The incident report did not document if he had been assessed by the RN or if and when the caregivers were instructed on how to care for him after the incident.<br><br>An incident report dated 7/15/07 at 8:00 PM documented Random Resident B "was in his bathroom and wet on the floor and he slipped on the urine and fell. He landed on his right hip, he was in very bad pain." Hospice instructed the caregiver to give morphine .25 mg at 8:30 p.m., and he continued to be in pain. The caregiver called hospice and was told to give him another | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 27<br>.25 mg of morphine. Hospice came and looked the resident over and called his guardian to decide what to do." The facility RN had signed the incident report on 7/18/07, 3 days after the incident. The incident report did not document what had happened after the incident nor did it give instructions to the caregivers regarding emergency intervention procedures and protocol that was to be followed.<br><br>An incident report dated 9/12/07 at 9:20 AM documented Random Resident D had fallen and sustained a bruise to his back after hitting the toilet. "Resident was taken to ER per son-in-law for x-rays. No broken bones, only bruises. will continue to monitor." The facility RN had signed the incident report on 9/13/07, 1 day after the incident. The incident report did not document the facility RN had been involved with the decision to send him to the ER.<br><br>An incident report dated 9/29/07 at 7:30 (not specified if AM or PM), documented Resident #1's "ankle was visibly swollen around 12 PM, employees watched it throughout the day. At around 7:15 eve noticed it has swelled more. At about 7:30 she got up to walk to her room and after 3 steps fell backwards. It was unknown if she hit her head but just for her safety we contacted paramedics and family." The facility RN was notified by caregivers on 9/29/07 between 7:30 and 8:00 PM of the fall. However, the incident report did not document if the caregivers had contacted the RN or emergency services when she had a swollen ankle for at least 7 1/2 hours prior to the fall.<br><br>On 10/16/07 at 11:40 a.m., the administrator stated there were no current policies and procedures for emergency services in the facility. | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 28<br><br>On 10/16/07 at 2:45 p.m., the facility RN stated when a resident had a fall the caregivers would notify the house manager, "I don't know where they write those (falls) down." The facility RN also stated when a resident had a change in condition the caregivers were to notify her and the family. She also stated if the resident had a significant change and had to be evaluated, "I don't usually come, I send them to the doctor."<br><br>On 10/16/07 at 3:20 p.m., a caregiver stated that in the event a resident falls the procedure is to "ask if they are okay or if they can stand up. If the resident says no, we call the family or the ER." Further, the caregiver admitted she had never called the nurse but did call the house manager once when a resident fell and hit her head. She said the house manager told her to call the daughter and the daughter said that it could wait.<br><br>On 10/16/07 at 3:25 p.m., a caregiver stated that in the event of an emergency the resident is "looked over, if something is wrong I call the family and if serious I call [house manager's name]. Further, the caregiver stated, "I really don't know how to tell if it's something serious, just by the look [of the resident] or the resident will tell me."<br><br>On 10/16/07 at 3:30 p.m., a caregiver stated the procedure in an emergency was to call 911 if choking or not breathing, otherwise to call the family and then the supervisor [house manager's name].<br><br>There were no clear policies and procedures to direct staff in an emergency. Unlicensed staff were conducting medical assessments and providing treatment rather than obtaining | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 29<br>emergency services or obtaining direction from the facility RN.<br><br>III. Development, Implementation and Updating of NSA's<br>1. Resident #2 was originally admitted to the facility on 8/19/04 with diagnoses including Alzheimer's Dementia and was re-admitted to the facility on 10/09/7 following a hospitalization for a hip fracture.<br><br>A. Resident #2's UAI/NSA dated 8/30/07 documented she required verbal cues to go to meals and staff were to cut the resident's food prior to serving. There was no documented evidence an interim plan of care or UAI/NSA had been developed after the resident was re-admitted on 10/09/07.<br><br>The daily care logs dated 10/9/07 to 10/15/07 (various shifts) documented the resident had eaten between 0% and 25% of her meals.<br><br>The facility nurse's notes dated 10/9/07 documented Resident #2 returned to facility from the hospital, "Appears to have lost a lot of weight."<br><br>The daily log notes dated 10/11/07 documented Resident #2 "refused solid food" and was "very weak."<br><br>The daily log dated 10/13/07 documented Resident #2 "ate a little, put head down on table."<br><br>The facility nurse's note dated 10/15/07 documented Resident #2 was "not eating well since admission. Choked on mashed potatoes this morning, requiring Heimlich to clear. Son notified. Will call [Doctor's name] and get orders | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 30<br>for hospice today." From 10/9/07 to 10/15/07 (7 days) there was no nursing documentation that addressed her diminished appetite nor documented communication to her physician nor direction to caregivers regarding her nutritional and hydration needs.<br><br>On 10/17/07 at 4:26 PM the hospice nurse stated Resident #2 was started on hospice today. She stated she had surgery for the fractured hip and had not "bounced back." She also stated Resident #2 was not consuming fluids and was "going into a negative swallow."<br><br>On 10/19/07 at 2:43 PM a caregiver stated Resident #2 had a decline in her health after her fall on 9/19/07 and had not been eating well. The caregiver stated she refused to eat or drink and began choking on oatmeal and mashed potatoes, but never did have a diet change.<br><br>On 10/19/07 at 3:30 p.m., a caregiver stated Resident #2 did not have an appetite. The caregiver stated she refused fluids and meals and began choking on oatmeal and mashed potatoes.<br><br>B. Resident #2's UAI/NSA dated 8/30/07 documented she was able to take care of her own toileting needs but required staff assistance with clean-up. She was "usually" able to walk independently and was independent with transfers. There was no documented evidence an interim plan of care or UAI/NSA had been developed after the resident was re-admitted on 10/09/07.<br><br>The facility nurse's notes dated 10/9/07 documented Resident #2 returned to facility from the hospital and was "able to stand," took three | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 31<br>steps with light hands on assist.<br><br>On 10/16/07 at 8:30 AM, Resident #2 was observed laying in her bed asleep. She did not respond nor open eyes when greeted. The caregiver said she "wasn't doing very well" and was on hospice.<br><br>On 10/17/07 at 3:00 p.m., a caregiver stated Resident #2 fell and broke her hip and "declined from then on." The caregiver stated she required total assistance with all cares and required position changes every 2 hours.<br><br>On 10/17/07 at 4:26 p.m., the hospice nurse stated Resident #2 was started on hospice today and as she had not "bounced back" from hip surgery.<br><br>The facility did not develop Resident #2's interim plan of care or NSA to instruct the caregivers on interventions to address her poor nutritional and hydration intake nor instruct the caregivers on how to provide cares to a resident with a repaired fractured hip.<br><br>2. Resident #6 was admitted to the facility on 7/15/06 with diagnoses including dementia, colon cancer, and macular degeneration.<br><br>Resident #6's closed record contained a UAI/NSA dated 2/17/07 which documented the resident required caregivers to cue and assist the resident with toileting every two hours. The caregivers were to provide stand by assistance for safety as needed with walker and to assist with transfers as needed.<br><br>A hospital "Patient Transfer Form" dated 5/21/07 documented Resident #6 was non-weight bearing | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 32<br>with the right lower extremity. A knee immobilizer was ordered PRN for non-weight bearing status.<br><br>HH admitted Resident #6 on 5/23/07 and assessed her as right non-weight bearing, unable to ambulate or to wheel self, unable to transfer self and unable to bear weight or pivot when transferred by another person. It also documented she had a large brace in her room and would be assessed by PT and OT for proper use.<br><br>The facility nurse's notes dated 5/26/07 document Resident #6 was bleeding from the rectal area and was sent to the ER for an evaluation. She was admitted to the hospital for nausea, vomiting and diarrhea and possible GI bleed and UTI. The resident was discharged back to the facility on 5/29/07 with an order for hospice.<br><br>The resident was admitted to hospice on 5/31/07, following her second hospitalization.<br><br>A hospice aide intervention sheet dated 6/7/07 documented Resident #6 was a 2-3 person assist during cares.<br><br>A hospice aide intervention sheet date 6/8/07 documented Resident #6 was a 2 person transfer at all times.<br><br>On 10/16/07 at 11:00 AM a HH/hospice staff stated Resident #6 was unable to bear weight or pivot, unable to wheel herself and was totally dependent on staff for all her cares.<br><br>The NSA had not been updated to include Resident #6's significant change in health status. There was no direction to staff regarding her non-weight bearing status and the use of the | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 33<br>brace. Further, neither HH or hospice services were included in the NSA which would have outlined the services provided by the outside agency.<br><br>3. Review of Resident #5's closed record on 10/16/07 revealed the resident was admitted on 4/18/07 with diagnoses which included dementia, hypothyroidism, hyponatremia, purpuric rash secondary to recent medications, prostatic hypertrophy and iron deficiency anemia.<br><br>A. Fluid Restriction: Resident #5's closed record on 10/16/07 contained an interim plan of care dated 4/3/07 which documented the resident was independent with eating and could feed himself. There were no instructions to caregivers about the resident requiring a fluid restriction.<br><br>Review of Hospital A's discharge summary dated 4/18/07 documented Resident #5 had "Hyponatremia, it appeared that the patient was drinking large amounts of water throughout the day." Discharge instructions included a 2200 calorie ADA diet with a 2 L fluid restriction.<br><br>A physician's order dated 4/18/07 documented Resident #5 was placed on a 2 L fluid restriction.<br><br>Review of Resident #5's closed record indicated that HH A was discontinued on 4/27/07. On 4/28/07 he was admitted for an unresponsive episode to Hospital B and remained there for 10 days then was re-admitted to the facility on 5/7/07.<br><br>Review of Hospital B's history and physical dated 4/28/07 documented "There was a history of significant PO intake of fluids at that time, 6 to 9 liters per day." It also documented Resident #5 | R 008 | | |

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| R 008 | Continued From page 34<br>presented to the emergency room with a low sodium level, but not as "severe" as when the resident was at Hospital A. Additionally, it documented the resident had "evidence of fluid overload...will treat with Lasix and fluid restriction."<br><br>Resident #5's closed record contained an interim plan of care dated 5/7/07, which documented the resident was independent with eating but needed reminded or cues to maintain adequate intake due to a poor appetite. There were no instructions to caregivers about the resident being on a fluid restriction.<br><br>Review of HH B's "Home Health Certification and Plan of Care" dated 5/8/07 documented the HH agency was to assess nutrition and hydration status and compliance with fluid restrictions.<br><br>HH B's nurses progress note dated 5/8/07 documented Resident #5 continued "to be difficult to monitor with fluids, esp. water intake, and they will try hard diabetic candy, gum, ice chips. He did cooperate with me when I told him he could not have water but this is problematic to the staff."<br><br>Resident #5's record contained a "Fax transmission/phone order" dated 5/9/07 which documented, "Resident returned to this facility with 1500 ml (1.5 liter) fluid restriction. We need to have this order removed because resident is ambulatory with dementia. His fluid intake cannot be monitored in this setting." The physician responded "pt. has polydipsia with associated hyponatremia, fluid restriction is medically required!!"<br><br>Resident #5's closed record contained a UAI/NSA dated 5/9/07, which documented he was | R 008 | | |

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| | 13R781 | A. BUILDING _____ B. WING _____ | 10/22/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| R 008 | Continued From page 35<br>independent with eating but needed reminded or cues to "come to meals." There were no instructions to caregivers about him being on a fluid restriction.<br><br>The facility did not develop Resident #5's interim plan of care or NSA to instruct the caregivers that a fluid restriction was required. From the time he was admitted on 4/18/07 until the time he was discharged on 5/17/07, there was no interim plan of care or NSA that documented he was on a fluid restriction or that the facility had been monitoring the his fluid intake.<br><br>B. Urinary retention/catheter care: Resident #5's closed record contained an interim plan of care dated 4/3/07, which documented he required SBA with toileting every 2 hours for safety. The Interim Plan of Care did not have instructions related to urine output and the need to call HH when there was no urine output after 8 hours.<br><br>Review of Hospital A's discharge summary dated 4/18/07 documented the resident had "prostatic hypertrophy" and had "some" urinary retention issues as well as "frequent" urinary incontinence.<br><br>A physician's order dated 4/19/07 documented "contact home care if no urine output every 8 hours."<br><br>HH A's "Start or Resumption of Care" dated 4/19/07 documented Resident #5 needed to be toileted every two hours.<br><br>HH A's "Generic Nursing Intervention" dated 4/19/07 documented Resident #5 had "cloudy, dark yellow and strong odor" urine. It also documented the caregivers "were unsure" of his urinary output. The HH nurse also documented | R 008 | | |

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| R 008 | Continued From page 36<br>she had "instructed ALF to call if no urinary output in 8 hours, agitation, or medication changes."<br><br>HH A's "Generic Nursing Intervention" dated 4/24/07 documented Resident #5's bladder was emptied and there was a large urine output."<br><br>HH A's "Generic Nursing Intervention" dated 4/25/07 documented the family members and caregivers were instructed to assist Resident #5 to the toilet every 2 hours.<br><br>Review of Resident #5's closed record indicated he was admitted to the hospital on 4/27/07 and remained there for 10 days then was re-admitted to the facility on 5/7/07. While hospitalized he had a Foley catheter placed and was discharged back to the facility with home health, which was initiated on 5/8/07.<br><br>Resident #5's closed record contained an interim plan of care dated 5/7/07 which documented the resident required physical assistance with some tasks that included: cleaning, putting on protective garments and clothing adjustments. It also documented the resident had a Foley catheter. The interim plan of care did not give instructions to caregivers on how often to change the resident's catheter bag, how to prevent or discourage the resident from pulling the catheter out or signs and symptoms to watch for in case the catheter was not working properly.<br><br>HH B's nurses progress note dated 5/10/07 at 6:45 PM documented the HH nurse visited Resident #5 due to him trying to remove the catheter with the possibility it could have been removed traumatically. He had a "preoccupation" with the catheter and the family members "expressed their inability to sit with Pt. to prevent | R 008 | | |

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| R 008 | Continued From page 37<br>wrong doing." The HH nurse gave catheter instructions to family members, but there was no documented evidence the facility caregivers had received similar instructions or had been trained in catheter care.<br><br>The facility's daily log note dated 5/10/07 on the 3-11 shift documented Resident #5 had pulled on the catheter and had some bleeding and pain, which the HH nurse evaluated. At around 9:20 PM a family member took him to the ER due to him not having any fluid in the catheter bag.<br><br>The facility's daily log note dated 5/10/07 on the 11-7 shift documented Resident #5 had not been complaining of pain, but he had been bleeding from the "penis" and the caregiver had cleaned the area twice. The caregiver documented "Everything seemed to be working properly emptied cath bag x 2."<br><br>The facility did not develop Resident #5's interim plan of care or NSA to guide the caregivers on monitoring and reporting the resident's urinary output prior to him being hospitalized on 4/28/07. When he was re-admitted on 5/7/07, the facility did not update Resident #5's interim plan of care or NSA to guide the caregivers on how often to change the his catheter bag, how to prevent or discourage him from pulling the catheter out or what signs and symptoms to watch for in case the catheter was not working properly<br><br>C. Assistance of Mobility: Resident #5's closed record contained an interim plan of care dated 4/3/07, which documented he was independent with transferring and changing positions. It also documented he required moderate assistance with mobility. The interim plan of care did not instruct the caregivers regarding his weakness | R 008 | | |

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|---|---|---|---|
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| R 008 | Continued From page 38<br>which resulted in him requiring a 2-3 person assist with mobility and transfers, or instruct the caregivers about his high fall risk or required use of a walker.<br><br>Resident #5's closed record contained Hospital A's "Last 24 hr Assessment Chart Copy" dated 4/18/07 documented he needed a 2 person assist with mobility and was "very inconsistent with mobility and at risk for falls."<br><br>Hospital A's discharge summary dated 4/18/07 documented Resident #5 wandered in the halls at the hospital and required the use of a walker and needed to "be monitored or have one-on-one attention when ambulating."<br><br>HH A's physical therapy note dated 4/19/07 documented Resident #5 was "dependent on all mobility." It also documented his balance was poor and required constant contact assistance to help maintain balance. It documented staff were "willing" to provide 2 person assist as needed.<br><br>HH A's "Generic Nursing Intervention" dated 4/21/07 documented Resident #5 was "unable to ambulate." His family members had planned to visit "frequently to assist" the facility with cares.<br><br>The facility's daily log note dated 4/22/07 on the 3-11 shift documented "has been walking around from one chair to another. [Resident] fell down when walking not hard no injuries. Another caregiver and I picked him up he was fine real hard to get back up on feet with 2 people."<br><br>HH A's "Generic Nursing Intervention" dated 4/22/07 documented Resident #5 was able to ambulate with a walker and 2 person assistance. | R 008 | | |

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|---|---|---|---|
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| R 008 | Continued From page 39<br><br>HH A's "Generic Nursing Intervention" dated 4/23/07 documented Resident #5 was "able to ambulate slowly with walker and caregiver assistance, unsteady."<br><br>HH A's "Generic Nursing Intervention" dated 4/25/07 documented Resident #5 was up at night without sleeping much of the time. The resident, family members and assisted living caregivers were instructed to have him use a walker with all ambulation and transfers.<br><br>HH A's "Patient Summary/Physician Orders" dated 4/27/07 documented the HH nurse had visited and assessed his safety and falls as he had continued "having several falls during the night time."<br><br>The facility did not develop Resident #5's interim plan of care or NSA to instruct the caregivers on his weakness and need for a 2-3 person assist with mobility and transfers, or instruct the caregivers about thehis high fall risk or required use of a walker.<br><br>D. Skin condition: Review of Resident #5's record on 10/16/07, revealed an interim plan of care dated 4/3/07 which documented he needed moderate assistance with bathing and needed some physical assistance to complete baths. There were no instructions for the caregivers on how to care for his skin condition when bathing, or how to provide wound care/dressings, or how to provide preventative measures to reduce skin breakdown.<br><br>HH A's "Start or Resumption of Care" dated 4/19/07 documented Resident #5's "rash covers torso/extremities, greater bilateral lower extremities and buttocks." It also documented the | R 008 | | |

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|---|---|---|---|
| | 13R781 | A. BUILDING _____ B. WING _____ | 10/22/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| R 008 | Continued From page 40<br>resident had "small blisters to bilateral lower extremities with no open areas noted as well as BLE "3 + edema."<br><br>HH A's "Generic Nursing Intervention" dated 4/21/07 documented Resident #5's "rash continues on body, covering more areas per family." Additionally, it documented he had the rash on the legs, groin, buttocks, upper body and hands. It also documented there were "some blisters forming on heels, none open."<br><br>HH A's "Generic Nursing Intervention" dated 4/23/07 documented Resident #5's rash on buttocks "appeared to be healing" but the BLE had large blisters that were "weeping."<br><br>"Hospital Doctor's Order and Progress Note" dated 4/23/07 at 4:40 p.m., documented the physician ordered the HH nurse to cleanse the open areas on the BLE with a wound cleaner, pat dry with a sterile gauze and cover open areas with gauze. The physician documented the gauze would need to be changed "when saturated or every 3 - 4 days." Additionally, the physician documented he required the application of a "Tubigrip, single layer to knees" on BLE.<br><br>Home Health A's "Generic Nursing Intervention" dated 4/24/07 documented Resident #5 had "very large blisters forming, one ruptured during dressing change, clear yellow fluid noted."<br><br>Review of Resident #5's record indicated that HH A was discontinued on 4/27/07. He was admitted the hospital on 4/28/07 and remained there for 10 days then was re-admitted to the facility on 5/7/07. HH B was initiated on 5/8/07.<br><br>Review of Resident #5's record on 10/16/07, | R 008 | | |

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|---|---|---|---|
| | 13R781 | A. BUILDING _____ B. WING _____ | 10/22/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| R 008 | Continued From page 41<br>revealed an Interim Plan of Care dated 5/7/07 which did not document the resident required any bathing assistance, skin care or wound care.<br><br>Review of HH B's "Home Health Certification and Plan of Care" dated 5/8/07 documented the caregivers were to "assess exudate, odor, pain, tissue color, redness of wound. Instruct in precipitating factors in precipitating factors to skin breakdown. Instruct in pressure relief/shearing reduction measures."<br><br>HH B's nurse's progress note dated 5/8/07 documented Resident #5 continued to have a diffuse rash on "his hands, fingers, legs and generally on most of his body. The staff at [facility] applies the [medication cream] BID but the family is concerned that it will again blister as it did a few weeks ago."<br><br>Resident #5's record contained an UAI/NSA dated 5/9/07 which documented the resident needed SBA with bathing 2 times a week. Caregivers were to stay with him until he had completed the bathing process (wash, dry and dress). There were no documented instructions or preventative measures related to wound care during or after bathing.<br><br>HH B's wound nurse progress note dated 5/9/07 documented Resident #5 had a rash to arms, legs and trunk. There are areas of dry eschar to the mid calf and posterior achilles." The wound nurse also documented the "eschar areas" needed to remain clean and dry and if the wounds began to drain, wound gel and dressings would need to be applied.<br><br>HH B's wound nurse progress note dated 5/11/07 documented Resident #5 was seen by the HH | R 008 | | |

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| R 008 | Continued From page 42<br>wound nurse due to a family member request as his "wounds on heels had opened." The HH wound clinic nurse gave the family written wound care instructions to provide daily dressing changes.<br><br>HH B's wound nurse progress note dated 5/13/07 documented a family member had contacted the nurse and stated "she changed leg dressings earlier today after pt. had an accident. No need for SNV today." Another family member to provide "wound care tomorrow."<br><br>On 10/16/07 at 3:00 p.m., the facility RN stated Resident #5 needed assistance with dressing and bathing.<br><br>On 10/17/07 at 9:38 a.m., a family member stated the resident had many different issues at the time he was at the facility. She stated the resident needed supervision at night as the resident would become confused and would be up walking. She stated the resident would sometimes become weak all of a sudden and would fall, but not usually hard. She stated that prior to the hospitalization at Hospital B the resident did not have a catheter but would go to the bathroom in the wrong location and would forget to go into the toilet. She also stated there were several times when the catheter bag had not been emptied and was full of fluid.<br><br>On 10/17/07 at 10:03 a.m. a second family member stated the resident needed assistance with mobility and when taking the resident to a physician's visit it took two family members to assist the resident with his walker. She stated the caregivers were not aware at first the resident had a Foley catheter after it was placed as family had to change the catheter bag. On one occasion | R 008 | | |

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| R 008 | Continued From page 43<br>the resident had pulled the catheter out and family had to call the home health agency to request a visit to assess the resident's bleeding and catheter. She also stated the resident would drink a large amount of water and had access to water in the facility. The family member stated the resident had open wounds on both ankles and his feet were very swollen. She stated the family had provided the wound care to the resident.<br><br>On 10/170/7 at 3:00 p.m., a caregiver stated the resident had blisters all over his legs when he was admitted into the facility. The blisters on his ankles started to have breakdown, HH was involved and bandaged his legs. She also stated he was heavy care initially, then improved and then became worse again. He wandered all of the time, he did not like to sit. The family was very involved and provided him with many of his care needs.<br><br>On 10/19/07 at 11:27 a.m., the HH wound nurse gave a statement in writing about Resident #5's wound care. She stated "it was my understanding, [family members] would be dressing the wounds."<br><br>The facility did not develop, implement or update Resident #5's interim plan of care or NSA to instruct the caregivers on his care needs.<br><br>The facility admitted and retained residents for whom the facility did not have the capability, capacity, and services to provide appropriate care for Residents #5 & #6. The facility failed to obtain emergency services for Residents #1, #2, #5, #6 and 5 random residents. This failure had the potential to affect 100% of the residents in the facility. Finally, the facility also failed to develop and implement an interim plan of care or NSA for | R 008 | | |

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|---|---|---|---|---|
| R 008 | Continued From page 44<br>Residents #2, #5 and #6. These failures resulted in Inadequate care. | R 008 | | |

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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November 15, 2007

Rita Berg, Administrator
Grace Memory Care of Nampa LLC
4356 North Nines Ridge Lane
Boise, ID 83702

Dear Ms. Berg:

On October 22, 2007, a complaint investigation survey was conducted at Grace Memory Care of Nampa LLC. The survey was conducted by Donna Henscheid, LSW, Polly Watt-Geier, MSW and Karen McDannel, Registered Nurse. This report outlines the findings of our investigation.

**Complaint # ID00002695**

Allegation: The facility was not conducting criminal background checks.

Findings: On October 16, 2007 at 9:00 a.m., a review of six employee records was conducted and four of six employees did not have their background checks completed at time of hire.

On October 16, 2007 one employee record documented the employee had no background check completed. Two other employees were hired in January 2006 and their background checks were not completed until March 15, 2007 which was approximately fourteen months after their date of hire. The fourth employee was hired October 23, 2007 and the background check was not completed until August 16, 2007 which was ten months after the date of hire.

Conclusion: Substantiated but not cited. The facility was not cited because the deficient practice was corrected. Although late, three of the four employees did have their background checks completed and were cleared to work. The fourth employee no longer works for the facility.

Allegation #2: Staff worked alone in the facility prior to having Cardiopulmonary Resuscitation (CPR) training.

Findings: Based on record review and interview it was determined the facility did schedule an employee to work alone without CPR training.

On October 16, 2007 at 9:00 a.m., six employee records were reviewed. One of the six employees had no documentation to confirm CPR training had been completed.

On October 16, 2007 at 10:35 a.m., the house manager confirmed the employee had not completed CPR training and had worked alone.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.b for not ensuring staff who worked alone were properly trained. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: Administration did not record or investigate staff concerns regarding the residents' cares.

Findings: Based on interview and record review, it could not be determined the facility had not responded to staff complaints regarding the residents' cares.

During the survey process October 16, 2007 through 10/18/07, 6 of 6 employees interviewed did not express concern regarding the handling of complaints regarding residents' cares.

On October 16, 2007 at 1:34 p.m., the complaint log was reviewed and contained no documentation of any complaints from staff, residents or families.

On October 16, 2007 at 1:37 p.m., the administrator and house manager stated they were not aware of any complaints from staff or families regarding residents' cares.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #4: A resident's narcotic log was altered. Entries were scibbled out or not recorded accurately. A notation next to a signature "not my signature" was scribbled out.

Findings: Based on record review it was determined that staff were not keeping precise narcotic records.

On October 16, 2007 at 1:30 the resident's narcotic logs for hyroco/APAP 5/500 were reviewed. One log was for hydroco/APAP 5/500 (1/2 tablet) PRN for pain and the other was for hydroco/APAP 5/500 (1 tablet) PRN for pain. Both logs were dated November 28, 2006 to December 24, 2006.

The narcotic log for the full tablet dated December 24, 2006 at 12:00 p.m., documented there were 19 tablets remaining, a space was left blank and the next entry on December 24, 2006 at 11:00 p.m. documented there were 21 tablets remaining. This was two tablets more than noted earlier that day.
The narcotic log for the 1/2 tablets dated December 18, 2006 at 8:00 p.m. documented there was 21 tablets remaining and a space was left blank. The next entry dated December 24, 2006 at 11:00 p.m., documented no medication was given but there was

19 (1/2) tablets remaining which was two tablets less than noted six days earlier. Also noted on the 1/2 tablet log was a signature of a staff person and written to the side of the signature was a notation "not my signature" which was scribbled out.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.03 for not ensuring narcotic records were kept accurately. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility employed a caregiver who was only 16 and was not a certified nursing assistant (CNA).

Findings: Based on interview and record review, it was determined the facility had employed a caregiver who was 16 years old and not a certified nursing assistant (CNA).

On October 16, 2007 at 9:00 a.m., four employee records were reviewed. One record documented an employee was hired on October 23, 2006 who was under 18 years of age. No documentation was found regarding this employee's nursing assistant certification. Further, review of the work schedule revealed this employee was listed to work several shifts throughout a six month timeframe.

On October 16, 2007 at 9:15 a.m., the house manager confirmed the employee was only 16 years old when hired. The house manager confirmed the registry was not checked prior to the employee being hired.

On October 16, 2007 at 9:55 a.m., the Regional CNA Registry was contacted and they confirmed this employee was not listed on the registry as certified.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215.12 for hiring an employee under 18 years of age who was not a CNA. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Polly Watt-Geier, MSW

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Polly Watt-Geier, MSW, Health Facility Surveyor

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

# ASSISTED LIVING
## Non-Core Issues Punch List

| Facility Name | Physical Address | Phone Number |
|---|---|---|
| Grace Memory Care of Nampa | 422 11th Ave South | (208) 442-8200 |
| **Administrator** | **City** | **ZIP Code** |
| Rita Berg | Nampa | 83686 |
| **Survey Team Leader** | **Survey Type** | **Survey Date** |
| Polly Watt-Geier | Complaint Investigation/ Standard Survey | 10/22/07 |

**NON-CORE ISSUES**

| ITEM # | RULE # 16.03.22 | DESCRIPTION | DATE RESOLVED | BFS USE |
|---|---|---|---|---|
| 1 | 150 | The facility did not have updated policies and procedures available to the staff to include emergency services intervention and acceptable admissions. | | |
| 2 | 215.12 | A caregiver who was under 18 and who had not completed a CNA course worked at the facility. | | |
| 3 | 300.01 | The facility's RN did not delegate all nursing functions to caregivers. | | |
| 4 | 310.01.b | Poisons, toxic chemicals and cleaning agents were stored in an unlocked area (i.e. laundry room). | | |
| 5 | 310.03 | The facility did not provide clear tracking of controlled substances. | | |
| 6 | 310.04.a | The facility did not attempt behavioral interventions prior to using behavior modifying medications. | | |
| 7 | 350.02 | The administrator or designee did not complete an investigation for each accident or incident | | |
| 8 | 350.07 | The facility did not notify the Licensing and Survey Agency within 24 hours of reportable incidents. | | |

| Response Required Date | Signature of Facility Representative | Date Signed |
|---|---|---|
| 11/22/07 | Rita Berg | 10/22/07 |

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**NON-CORE ISSUES**

| ITEM # | RULE # 16.03.22 | DESCRIPTION | DATE RESOLVED | BFS USE |
|---|---|---|---|---|
| 9 | 600.06.b | The facility had a caregiver work alone on the night shift without CNA/First Aide certification. | | |
| 10 | 625.01 | 1 of 3 personnel records did not have 16 hours of orientation. | | |
| 11 | 630.01 | 1 of 3 personnel records reviewed did not have specialized training related to dementia. | | |
| 12 | 730.01.g | The facility RN did not complete a criminal history clearance. | | |

| Response Required Date | Signature of Facility Representative | Date Signed |
|---|---|---|
| 11/22/07 | Rita Berg | 10/22/07 |

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**NON-CORE ISSUES**

| ITEM # | RULE # 16.03.22 | DESCRIPTION | DATE RESOLVED | BFS USE |
|---|---|---|---|---|
| | | (11/8/07) A portion of the core deficiency citations was reduced to a punch list item as follows: | | |
| 13 | 305.02 | The facility RN did not ensure Residents #2 and #4 had current medication orders. | | |

| Response Required Date | Signature of Facility Representative | Date Signed |
|---|---|---|
| 11/22/07 | | |